

forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by long-term care hospitals, effective with cost reporting periods beginning on or after October 1, 2002.

(14) Subpart P describes the prospective payment system specified in paragraph (a)(3) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital-related costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation units effective with cost reporting periods beginning on or after January 1, 2002.

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§412.2 Basis of payment.

(a) *Payment on a per discharge basis.* Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in §412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that are extraordinarily costly to treat.

(b) *Payment in full.* (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.

(2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare

payable day of care. Payable days of care, for purposes of this paragraph include the following:

(i) Limitation of liability days payable under the payment procedures for custodial care and services that are not reasonable and necessary as specified in §411.400 of this chapter.

(ii) Guarantee of payment days, as authorized under §409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.

(3) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at §412.23(e) to be paid as a LTCH, during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Medicare will not make payment under subpart H for any part of the hospitalization. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will be made in accordance with the requirements specified in §412.521. The requirements of this paragraph (b)(3) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

(c) *Inpatient operating costs.* The prospective payment system provides a payment amount for inpatient operating costs, including—

(1) Operating costs for routine services (as described in §413.53(b) of this chapter), such as the costs of room, board, and routine nursing services;

(2) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;

(3) Special care unit operating costs (intensive care type unit services, as described in §413.53(b) of this chapter);

(4) Malpractice insurance costs related to services furnished to inpatients; and

(5) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary during the 3 calendar days immediately preceding the date of the beneficiary's admission

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to the hospital that meet the following conditions:

(i) The services are furnished by the hospital or by an entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

(ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).

(iii) For services furnished on or after October 1, 1991, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:

(A) Ambulance services.

(B) Maintenance renal dialysis.

(d) *Inpatient capital-related costs.* For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.

(e) *Excluded costs.* The following inpatient hospital costs are excluded from the prospective payment amounts and are paid for on a reasonable cost basis:

(1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§413.130 and 413.157, respectively, of this chapter.

(2) Direct medical education costs for approved nursing and allied health education programs as described in §413.85 of this chapter.

(3) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in §405.521 of this chapter.

(4) The acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) incurred by approved transplantation centers.

(5) The costs of qualified nonphysician anesthesiologists' services, as described in §412.113(c).

(f) *Additional payments to hospitals.* In addition to payments based on the prospective payment system rates for inpatient operating and inpatient capital-related costs, hospitals receive payments for the following:

(1) Outlier cases, as described in subpart F of this part.

(2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in §412.105 for inpatient operating costs and in §412.322 for inpatient capital-related costs.

(3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in §412.115.

(4) Bad debts of Medicare beneficiaries, as provided in §412.115(a).

(5) ESRD beneficiary discharges if such discharges are ten percent or more of the hospital's total Medicare discharges, as provided in §412.104.

(6) Serving a disproportionate share of low-income patients, as provided in §412.106 for inpatient operating costs and §412.320 for inpatient capital-related costs.

(7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.

(8) For discharges on or after June 19, 1990, and before October 1, 1994, and for discharges on or after October 1, 1997, a payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia. For discharges occurring on or after October 1, 2005, the additional payment is made based on the average sales price methodology specified in Subpart K, Part 414 of this subchapter and the furnishing fee specified in §410.63 of this subchapter.

(9) Special additional payment for certain new technology as specified in §§412.87 and 412.88 of Subpart F.

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§412.4 Discharges and transfers.

(a) *Discharges.* Subject to the provisions of paragraphs (b) and (c) of this section, a hospital inpatient is considered discharged from a hospital paid under the prospective payment system when—

(1) The patient is formally released from the hospital; or

(2) The patient dies in the hospital.

(b) *Acute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of payment under this part if the patient is readmitted the same day (unless the readmission is unrelated to the initial discharge) to another hospital that is—

(1) Paid under the prospective payment system described in subparts A through M of this part; or

(2) Excluded from being paid under the prospective payment system described in subparts A through M of this part because of participation in an approved statewide cost control program as described in subpart C of part 403 of this chapter.

(c) *Postacute care transfers.* A discharge of a hospital inpatient is considered to be a transfer for purposes of this part when the patient's discharge is assigned, as described in §412.60(c), to one of the qualifying diagnosis-related groups (DRGs) listed in paragraph (d) of this section and the discharge is made under any of the following circumstances:

(1) To a hospital or distinct part hospital unit excluded from the prospective payment system described in subparts A through M of this part under subpart B of this part.

(2) To a skilled nursing facility.

(3) To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

(d) *Qualifying DRGs.* (1) For a fiscal year prior to FY 2006, for purposes of paragraph (c) of this section, and subject to the provisions of paragraph (d)(2) of this section, the qualifying DRGs must meet the following criteria for both of the 2 most recent years for which data are available:

(i) The DRG must have a geometric mean length of stay of at least 3 days.

(ii) The DRG must have at least 14,000 cases identified as postacute care transfer cases.

(iii) The DRG must have at least 10 percent of the postacute care transfers occurring before the geometric mean length of stay for the DRG.

(iv) If the DRG is one of a paired DRG based on the presence or absence of a comorbidity or complication, one of the DRGs meets the criteria specified under paragraphs (d)(1)(i) through (d)(1)(iii) of this section.

(v) To initially qualify, the DRG must meet the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section and must have a decline in the geometric mean length of stay for the DRG during the most recent 5 years of at least 7 percent. Once a DRG initially qualifies, the DRG is subject to the criteria specified in paragraphs (d)(1)(i) through (d)(1)(iv) of this section for each subsequent fiscal year.

(2) For purposes of paragraph (c), a discharge is also considered to be a transfer if it meets the following conditions:

(i) The discharge is assigned to a DRG that contains only cases that were assigned to a DRG that qualified under this paragraph within the previous 2 years; and

(ii) The latter DRG was split or otherwise modified within the previous 2 fiscal years.

(3) For fiscal years beginning with FY 2006, for purposes of paragraph (c) of this section—

(i) The qualifying DRGs must meet the following criteria using data from the March 2005 update of the FY 2004 MedPAR file and Version 23.0 of the DRG Definitions Manual (FY 2006):